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Editor's note

As well as criticising the authors of the paper in the *Journal of Medical Ethics*, Professor Kottow also implicitly criticises "the editors" for failing to "offer some clarity on the research ethics involved". When a paper submitted to the *Journal of Medical Ethics* has been accepted by its reviewers, and is found acceptable by the editor, and (where appropriate) has had approval by a relevant research ethics committee, then this editor would only consider offering "some clarity on the research ethics involved" if he perceived some major ethical problem concerning the conduct of the research. While understanding the dilemma referred to by Professor Kottow, the editor did not consider it necessary or appropriate to add his comments. However, papers addressing this area (ethical aspects of potentially intrusive enquiry) would be welcomed, subject to the journal's usual policy of peer review.

Causing death or allowing to die? A rejoinder to Randall's comments

SIR

Dr Randall has written a thought-provoking response to my paper,¹ but I fear that she has overextended and overgeneralised my arguments.

Causation

I argued that the withdrawal of feeding from a persistent vegetative state (PVS) patient could be regarded as the cause of that patient's death.² Dr Randall claims that if this is accepted, "then it must follow that in all cases where doctors have withheld or withdrawn life-prolonging treatment for any reason they have caused the patient's death" (my emphases). This does not follow. A distinction has to be drawn between starving someone who is unable to feed himself, or herself (such as a baby or bed-ridden patient) and ending attempts at emergency resuscitation. Surely one could not withdraw or withhold nutrition and hydration from terminally ill cancer patients, and then argue that their deaths were caused by the underlying disease? In many cases in which treat-

ment is withdrawn from a patient, who dies shortly thereafter, it is clear that the treatment had merely been prolonging the dying process. The difference in the PVS cases is that such patients are not generally regarded as being terminally ill.

Intention

Dr Randall argues that the doctors in the PVS cases do not themselves believe that they intend to cause their patient's death, hence cannot be said to "intend to kill". This flies in the face of the legal position, as described by the judges in the House of Lords in the Bland case, and the quotations I included from Lords Mustill and Browne-Wilkinson make clear that, in law, the doctors did intend to bring about Mr Bland's death. So far as the law is concerned, if a person has foreseen something as a virtually certain consequence of his or her actions, then that person can be said to "intend" that consequence, even if he or she does not "desire" that particular result. No one would claim that doctors ever "desire" their patients' deaths, but for legal purposes their intentions are quite another thing. Hence a terrorist who deliberately blows up a plane to attract publicity to his cause could be held by the law to have intentionally killed the plane's passengers (and hence could be charged with their murder) even if the terrorist did not actually desire their deaths, and indeed, even if the terrorist genuinely hoped that no one would be killed. It is enough that the deaths were foreseen by him as a virtually certain consequence of his act.³

Indistinguishable cases?

Dr Randall asserts that my major premise is that "morally indistinguishable cases should not be treated differently by the law". I made no such claim. Indeed, I conceded in my conclusion that even if certain omissions are morally equivalent to positive acts, "there may be good reasons of public policy for the strong stance which the law takes against positive acts [as opposed to omissions] which are intended to take life". According to Dr Randall, my arguments lead to the conclusion that "...if allowing to die is permitted in the PVS cases ... then so must non-voluntary euthanasia be permitted". I am at a loss to understand where this conclusion comes from - part of the point of my paper was to point out the irony, as I saw it, of the fact that the patient *did* consent to her own death in

the Cox case, while the PVS patients did not so consent (since they were obviously incapable of so doing) yet Dr Cox was prosecuted while the doctors in the PVS cases were not. The aim of my paper was simply to describe the legal reasoning in the Cox case, and contrast this with the legal response to the PVS cases, and to question whether these legal approaches were consistent. I certainly did not suggest that "compulsory non-voluntary and indeed involuntary euthanasia" be legalised. In particular, at no point in my paper did I advocate that the law ignore the need for patient consent - indeed I specifically state that my arguments relate to the desire of patients for a quick death where this "is requested by the patients themselves".

This is linked to Dr Randall's final contention, that my reasoning would make it legally obligatory to administer lethal injections to patients. She describes relatives as having a similar obligation, and paints a horrific picture of the potential consequences. I fear that she has once again overstated my case, and confuses the difference between the law making something permissible, and making it mandatory. My argument was rather that, if one accepts that in certain circumstances it is more humane to administer a lethal injection than to prolong a patient's dying by withdrawing feeding, then the law ought to give some credence to this. The "moral obligation" referred to by Beloff is to support the argument in favour of positive acts of euthanasia, in certain circumstances. "Legal recognition" of this would mean that the law would support the doctor who took steps, similar to those of Dr Cox, to end a terminally ill (and consenting) patient's life by lethal injection. This would mean that such doctors would not face prosecution. It does not mean that it would become mandatory for doctors to kill their patients, nor that doctors (or relatives) should be prosecuted for not doing so.

References

- 1 Ferguson PR. Causing death or allowing to die? Developments in the law. *Journal of Medical Ethics* 1997;23:368-72; Randall F. Why causing death is not necessarily morally equivalent to allowing to die - a response to Ferguson. *Journal of Medical Ethics* 1997;23:373-6.
- 2 There is concern amongst some doctors that a patient in a PVS may suffer when hydration and nutrition is withdrawn. Bissett-Johnson A, Ferguson PR. Striving to keep alive? Care and treatment decisions affecting severely handicapped patients in Britain. *European Journal of Health Care Law* 1997; 4(4):321-45.

3 Ashworth A. *Principles of criminal law*. Oxford: Clarendon, 1995:169 on.

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Why causing death is not necessarily morally equivalent to allowing to die - a response to Ferguson

SIR

Dr Randall's conclusion that causing death is not necessarily morally equivalent to permitting it is entirely correct but it is not based on sound reasoning.¹

If a patient in the permanent vegetative state (PVS) is nourished there is an obvious intention that he or she should live. If that nutrition is withdrawn there is an even more certain intention that he or she should die.

Causing the death of the PVS patient by withdrawing nutrition is intentional in a way that causing death by double effect is not. Dr Randall is presumably neither surprised nor displeased when analgesia which might shorten life actually prolongs desired pain-free life. Those who withdraw nutrition from PVS patients would be both surprised and displeased if doing so did not shorten life in the PVS. In one case analgesia is wanted but in the other death.

Nor is it morally relevant that the PVS patient dies of the disease after the withdrawal of nutrition. Otherwise a doctor could decline to ventilate or stop ventilating a patient with recoverable acute polyneuritis and then claim that the patient was killed by the disease not the doctor. A doctor is morally (and usually legally) responsible for all that he or she does, stops doing or decides not to do. The moral difference between the polyneuritis and the PVS patients is that the former should be kept alive and the latter should not.

The law recognises this by declaring that at a certain point in time the nutrition of PVS patients ceases to be a benefit to them and therefore the duty of care to provide it also ceases.

There is a moral difference between deliberate killing on the one hand and causing death by double effect, by inaction or by stopping action on the other hand, even though the motive is benefit to the patient in each case. The difference lies in the damaging extended effect of allowing doctors to kill deliberately by direct action. For example progress in Dr Randall's own

specialty of palliative medicine might be impeded.

References

- 1 Randall F. Why causing death is not necessarily morally equivalent to allowing to die - a response to Ferguson. *Journal of Medical Ethics* 1997;23:373-6.

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The ethics of human cloning

SIR

Harris¹ in his recent article in the journal rightly decries the lack of carefully reasoned debate on the ethics of human cloning. In drawing attention to the use of nuclear transfer and embryo-splitting technology as differing little from sporadic monozygotic twinning and currently utilised in vitro embryo biopsy techniques, many of the stated ethical concerns surrounding cloning appear diminished if not unsubstantiated.

However, in suggesting that the central principle of Kantian ethics, that an individual should not be considered in terms of his or her utility but always primarily in terms of his or her intrinsic worth, as seldom helpful in debate in this area, he is too dismissive. A fundamental difference between sexual and asexual reproduction (as represented by cloning) is that in the latter a substantial proportion of the individual's makeup can be predicted and anticipated. Environmental influences certainly guarantee that phenotypic duplication is very unlikely to be achievable but nevertheless the influence of genetic factors on physiology and behaviour, particularly those associated with complex traits, are frequently underestimated. If cloning technology was to be employed so as to create an individual genetically identical to that of a pre-existing person, there is no entailment of a breach of one of the central tenets of Kantian thought - that we always treat people as ends in themselves and never merely as means. Sexual reproduction, of course, does not prevent prospective parents or society from being motivated by the expected utility of a fetus or child, but the intrinsic genetic randomness of the process all but denies any guarantee of the desired outcome. In contrast cloning promises considerable success in this respect and may present the greatest opportunity so far in history

actually to treat people merely as means and not as ends.

Interventions such as currently used techniques in prenatal diagnosis, including genetic analysis by embryo biopsy, are an exception to this rule. We can predict and determine the nature of the being brought into existence. In these instances, however, the motivation for the test is the utility being attached to the presence or absence of a discrete disease or condition, is overtly stated and open to societal sanction (for example testing for Down's syndrome, spina bifida, cystic fibrosis) or not (sex selection for sociocultural reasons). The limits of infraction of the Kantian principle can thus be determined. The replication of genetically identical individuals, however, presents the opportunity for abuse, since the motivation for employing such a mode of reproduction need not be overtly stated and can easily escape critical examination by society. Open critical examination of the basis by which genetic traits are selected for is necessary if doctors are to escape the all-too-familiar accusation of pursuing some eugenic agenda. Quite clearly, human reproduction is not presently free of breaches of Kant's central tenet (for instance programmes aimed at the intrauterine diagnosis and subsequent destruction of fetuses with Down's syndrome), but the introduction of cloning would remove the possibility for the critical ethical scrutiny that such decisions demand.

Harris goes on to offer a framework of reproductive autonomy as a philosophical basis on which to develop ethical approaches to questions such as these. In the particular instance stated above (asexual reproduction of human beings prescient of the entire phenotype of the "parent") no public legislative, ethical or medical body could safeguard the ethical use of cloning technology when the motivations of parents remain opaque and the consequences for the individual who results are considerable. Despite the many conceivable meritorious grounds for use of this technology for reproduction the grounds for a prohibition on cloning, at least in this context, seem strong.

Acknowledgement

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References

- 1 Harris J. "Goodbye Dolly?" The ethics of human cloning. *Journal of Medical Ethics* 1997;23:353-60.

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